NHS Borders

Local Mobilisation Plan 4 – Responding to COVID-19

1st May 2020

Final Version

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Introduction

This is the fourth iteration of the NHS Borders COVID-19 Local Mobilisation Plan (LMP).

The plans have been developed on modelling undertaken locally by NHS Borders staff based on work previously undertaken and published by Imperial College[1]. The local model has subsequently been updated on receipt of national modelling released by Scottish Government on 8 April 2020.

On 12th March the UK government moved from the Containment phase to the Delay phase in response to the ongoing coronavirus (COVID-19) outbreak. This has required us to refresh our plans around how patients are received and admitted to hospital. It has also required us to revisit our modelling assumptions. This LMP reflects these changes.

As we move forward to consider how to recover and remobilise health services within the Scottish Borders, it is anticipated that this will be the last iteration of our COVID-19 LMP. Any significant changes from the plan will be recorded through the Pandemic Committee process as specific operational decisions. The next phase of addressing COVID-19 will be the development of an NHS Borders Board recovery plan.

ITU & HDU Capacity

ITU & Ventilators

NHS Borders substantive ventilator capacity is for 5 Draeger Evita ITU vents sited within the Borders General Hospital (BGH). Following a request from Scottish Government to quadruple capacity to 20 and following guidance from Health Facilities Scotland to convert anaesthetic machines to be air driven modifications were made to our local equipment which gave a ventilator capacity as set out in the following table:

Equipment	Number
ITU ventilators	5
Anaesthetic machines (Aisys) modified to be air driven	6
Anaesthetics machines (care station 650) modified to be air driven	4
Anaesthetic machines (Drager Primus) donated by Royal Hospital for Sick Children (Edinburgh)	4
TOTAL	**19**

[1] *Ferguson NM et al. Impact of non-pharmaceutical interventions (NPIs) to reduce COVID-19 mortality and healthcare demand. WHO Collaborating Centre for Infectious Disease Modelling; MRC Centre for Global Infectious Disease Analysis; Abdul Latif Jameel Institute for Disease and Emergency Analytics; Imperial College Covid 19 Response Team. March 2020*

In recognition that using adapted anaesthetic machines to support ITU patients is not ideal (they require high flows of oxygen, require soda lime and have a large footprint for a small bed space) Scottish Government planned to source 5 ventilators from stock allocated to Scotland. These have not yet been received.

In the absence of further new ventilators we will be required to continue using the adapted machines noting their limitations. We do still have a transport ventilator and a NIV machine with invasive ventilation capability so will be able to ventilate 20 patients if required, although neither of these is an ideal option.

Due to constraints in relation to space, nurse staffing and oxygen it will not be possible to increase our ventilated critical care beds above the 20.

HDU & CPAP

As well as creating capacity for up to 20 ITU beds we have also created an additional combined HDU with 8 beds. The HDU beds came on stream on 4th April 2020. These beds will initially be staffed through a combination of redeployed clinical nurse specialists and theatres/ward staff. We require an additional combined HDU to allow us to bring back some elective work back on stream as within NHS Borders we have a combined ITU/HDU which may restrict our capacity to increase elective surgery

This is a facility where level 2 care can be delivered, including administration of inotropes and non-invasive ventilation for CPAP as a mode to support patients with COVID-19 virus. Where bed space allows, our plans are to provide CPAP in intensive care as the risks of deterioration to sudden requirement for invasive ventilation appear high. In patients who are not suitable for invasive ventilation and the ceiling of treatment is CPAP, this will be provided in HDU.

Post-operative non-COVID-19 HDU beds are a requirement for scheduled colorectal cancer surgery, and currently this is being provided through ward 5. This has required significant up-skilling of the ward 5 nurses and alteration of patient pathways. We are currently looking at more permanent solutions to this

Oxygen

We highlighted in our previous LMPs that we were extremely concerned around providing an adequate supply of oxygen per minute to meet predicted demand within the BGH. The key problem is the rate of oxygen flow into the piped supply may be insufficient.

We have been working closely with colleagues from Health Facilities Scotland over this concern and have made all of the modifications to the oxygen plant that have been recommended in order to ensure the maximum distribution of oxygen from it.

In addition, we have undertaken some modelling based on assumptions of how much oxygen additional patients with COVID-19 will use. The model is updated on a twice daily basis using data of how much oxygen such patients actually use. We are using this to calculate the estimated demand for oxygen over time. We are comparing this to the new rated maximum flow of oxygen from the vacuum insulated evaporator (VIE) of 1086 litres per minute (increased from 750 litres per minute before the adaptations were made).

As with any hospital, if we approach maximum oxygen capacity there is a risk of sudden oxygen supply failure. However, we have put in place monitoring and mitigating interventions to make this much less likely. We would seek urgent discussions regionally / nationally to consider transporting Borders patient to other facilities before compromising the care of patients within the BGH. This would initially be through regional mutual aid and discussions have taken place between the Chief Executives and Medical Directors of NHS Fife, Lothian and Borders and a commitment secured to supporting each Board as far as is practicable. During the most recent surge, with the adaptations put in place, we did not exceed 30% of our new upgraded capacity. Whilst exceptionally unlikely, should the BGH approach the maximum delivery from our plant then there is a risk of sudden catastrophic failure of oxygen delivery and this should be noted.

In terms of oxygen cylinders, we are working to ensure that patients on low-flow oxygen are supported with the cylinders rather than putting additional demand on the piped supply. We now have access to 33 oxygen concentrators which will give an additional 130l/min of O2 supply.

Nurses in ITU

In earlier discussions regarding ITU there was a commitment to maintain an ITU trained nurse to patient ratio of 1:3 with other nurses or Physiotherapists supporting in order to support as good care as possible. If we are required to increase our capacity to 20 ventilated patients we would then review our nurse patient ratio in line with guidance from the CNO recognising the potential risk to safety and quality.

We are aware of the challenging and difficult working conditions for nursing staff in ITU in terms of workload and the wearing of PPE for long periods. In order to minimise this we are putting in various measures to try and improve the conditions for staff. This includes within ITU staff having short breaks every two hours to ensure they have regular rest, rehydration and able to remove PPE frequently aiming to prevent any harm to skin and dehydration.

Medical Staffing

We have increased the amount of medical staff available each day by removing the concept of weekends, cancelling annual leave and maintaining a 12.5 hour shift pattern in order to ensure adequate skill and seniority are available at all times. In addition to this we have built a rota of junior doctors with previous experience in intensive care to support the existing structures consultants and middle grades. The ability to maintain this level of medical staff will be dependent on staff sickness moving forward.

In addition, whilst this model of staffing was absolutely necessary in our initial response phase to COVID-19, this is currently under review to see if any staff can be released from on-call commitments to allow elective services to be re-established.

Elective Surgery

Our original intention had been to offer urgent surgery only given that we have no capacity for post-operative critical care except in exceptional cases, and staffing constraints in theatre make it a significant logistical challenge to run an elective list alongside an emergency list. Since then we have been working with Scottish Government colleagues to secure the use of a private hospital in

Edinburgh for high priority elective cases, with NHS Borders providing the surgeons to allow our urgent cancer surgery to be carried out. This commenced on 20th April 2020 and will initially consist of breast surgery one day per week at Spire Murrayfield.

Locally, whilst urgent surgery had been paused for four days to enable ITU workforce capacity, the 5-day urgent surgery service has resumed in theatres. This provision is currently being planned week to week in recognition of the potential need to flex theatre capacity to support COVID-19 ITU demands. Significant work is underway to try to restore as much of our elective operating as possible, without compromising quality of care. For week beginning 20th April we ran a 'vertical booking' theatre list every day and aim to increase this in future weeks. This must be kept fluid, and we will need to be able to respond rapidly to peaks in critical care activity, meaning we must retain the ability to reduce our elective capacity and free up staff at short notice if this is required. Planning for this will be factored into our recovery plans.

NHS Borders COVID-19 Modelling Outputs

The Borders COVID-19 model was developed in mid-March to track and predict COVID-19 demand based on an assumption of an exponential increase in cases. The model is based around the Lothian model and predicts based on expected daily increase in rate. The initial trajectories for COVID-19 increase indicated we would require 300 - 350 general hospital beds to be available for COVID-19+ and suspected patients at the peak of the pandemic with a predicted peak between 9th and 13th April. At that stage we had only 10 days of actual data on which to test against the model. We have continued to update the modelling work on a daily basis with a rolling 5 day average of actual data.

Following circulation of the national modelling work commissioned by Scottish Government, we adjusted our local model to reflect the expected trajectory of increase and amended our predicted peak of demand for hospital beds to week commencing 4th May.

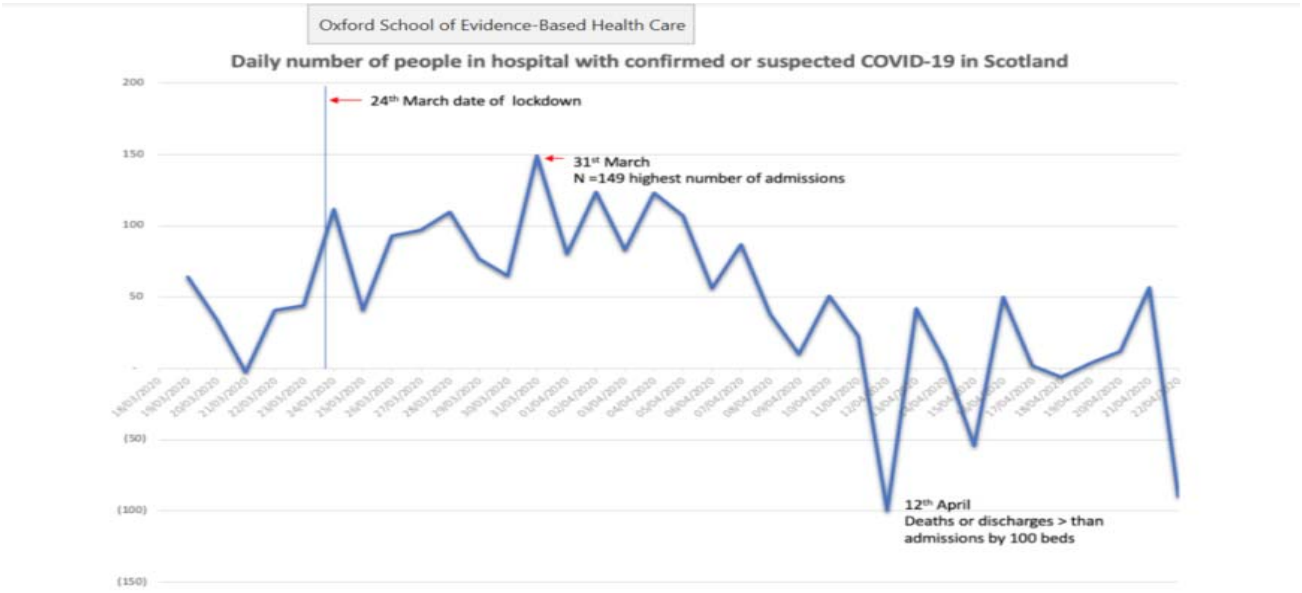
We have established trigger points of 100 occupied hospital beds and 13 occupied ITU beds to ensure that NHS Borders was in a position to manage worst case scenario demand.

A number of changes mean that the current COVID-19 model is no longer providing the data the organisation requires to plan services and we therefore intend to revise it to address this and continue to deliver predictive advice in support of operational planning of services.

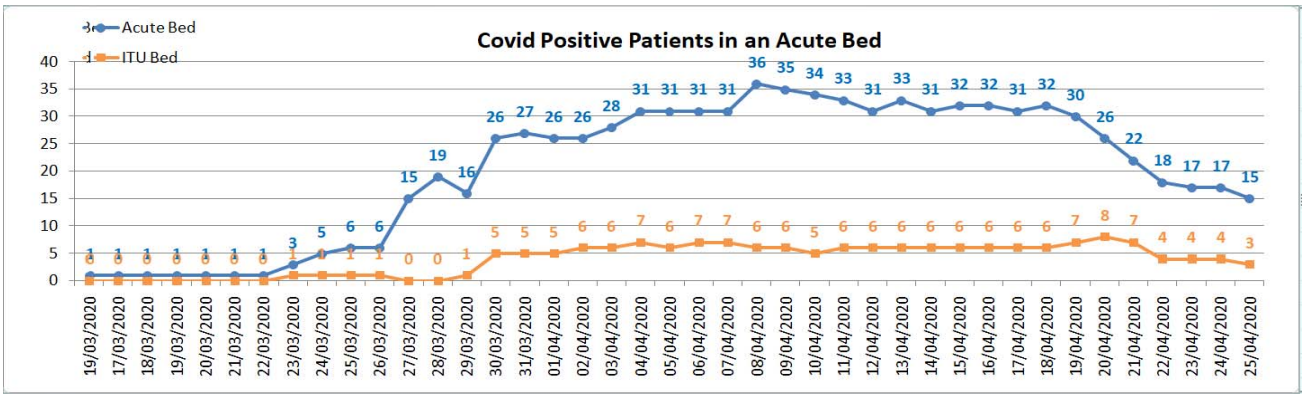
The changes are as follows:

1. There is evidence that NHS Borders has passed peak COVID-19 demand and it is unclear whether we are currently in a downward curve or a plateau in infection rate.

Analysis by the Oxford School of Evidence Based Healthcare suggests that the Scotland peak has passed:



This fits with our local data indicating that our peak was on 8th April:



Therefore, our current triggers and predictors are no longer reliable and need to be revised. These will be built into our future recovery plan.

2. The current model is based on new positive tests and the criteria for tests is changing

The model assumes that positive tests are 6% of total population infections and this provides the basis for calculating health care demand. However, as the criteria for testing is now being greatly extended, this means that the population proportion being tested will be larger. This will invalidate the assumptions built into the model and make predictors inaccurate.

3. The model reports test-positive cases only but test-negative clinical positive cases are significant.

The COVID-19 tests are known to have a significant false negative rate and clinical staff are identifying patients with high suspicion of COVID-19 where tests are negative. These patients will require management down a COVID-19 pathway, including access to COVID-19 beds, even though testing negative. They appear to be a significant percentage of the COVID-19 resource demand – indications are that this may be up to 50% of the total COVID-19 admission numbers.

The model is based on COVID-19 positive predicted admissions only and therefore significantly underestimates the 'true' COVID-19 demand.

In order to address these issues, we are adjusting the model as follows:

1. We will use the rate of hospital admission, rather than number of positive cases to build assumptions of resource demand. Hospital admission demand as a percentage of infected population will not change regardless of the number of cases identified. It also is directly relevant to the demand for healthcare resources. We will continue to report the rate of increase for predicted positive cases as a comparator

2. We will agree assumptions of test-negative COVID-19 demand based on clinical advice and current experience. We will also work with the operational services to establish robust mechanisms for monitoring and recording activity for these groups of patients (Cohort 2).

3. We will identify and incorporate tools for identifying natural and special cause variation to act as early warning triggers for changes in demand and activity

We expect this will provide a model that is fit for purpose during this new phase of the pandemic and able to adjust to future waves of infection. It will also allow us to develop revised early warning triggers of increased (or decreased) capacity demand that will allow services to adjust. The revised model should be complete by 1st May and will again be revised daily and reviewed twice weekly to confirm that service capacity is sufficient to meet demand.

Further modelling developments

Our model already provides planning data for hospital COVID-19 bed capacity, ITU capacity and oxygen demand. We will be extending its modelling reporting to include:

- PPE demand
- Single-room admission demand
- Downstream and non-COVID-19 demand
- Social care demand
- Primary and community care demand

The updated modelling will feed into our recovery planning process.

Scaling Up Bed Capacity

General Hospital Bed Demand

Based on the updated modelling work outlined above we have now scaled back our current open COVID-19 beds to the following:

Ward Name	Inpatient surgery plan	Bed Capacity Created	Cumulative Total
CV1	MKU (Full unit)	8	8
CV2	BSU	14	22
CV3	Ward 14	30	52
CV Assessment	MAU	30	82
CV Assessment	AAU	7	89

This is the bed base we anticipate operating for COVID-19+ and suspected patients within the BGH in the coming months, although this will be kept under review as we develop our recovery plan. Not including paediatrics and maternity, we currently have a total of 105 non COVID-19 beds available within the BGH and anticipate we will continue to operate at this level.

As a contingency however we are retaining the capacity to readily scale up to 156 beds if required during any future influenza peak. This is a reduction from the 280 beds that we originally predicted as our maximum COVID-19 beds to Scottish Government. The maximum COVID-19 bed capacity can be created through the following:

Ward Name	Inpatient surgery plan	Bed Capacity Created	Cumulative Total
CV1	MKU (Full unit)	8	8
CV2	BSU	14	22
CV3	Ward 14	30	52
CV5	Ward 17 / PAU	22	74
CV4	Ward 12	29	103
CV6	Ward 16	16	119
CV Assessment	MAU	30	149
CV Assessment	AAU	7	156

As highlighted in the modelling section above, we have built in trigger points and have regular reviews in place which will support decision making to flex capacity up as required. Should we require more than 156 general beds it is assumed these will have to be provided through other measures, which could include mutual aid.

We are currently experiencing reduced non COVID-19 related activity, including a reduction in ED attendances of 50% and a 59% reduction in occupied bed days for non COVID-19 general medical patients since 19th March. This reduction is also impacting on both outpatient and inpatients waiting times as of 13th April 2020 our cumulative lost outpatient activity was 8855 and inpatient lost activity was 414. We have factored some of this reduced activity into our planning at this stage but not all of it as we recognise this may be a temporary reduction.

ITU Demand

Modelling is indicating an expected maximum demand of up to 20 ITU beds by mid-May. As highlighted earlier we have identified plans that would allow us to establish a maximum 20 ventilated ITU beds and our current assessment is that we can staff up to the 20 beds. If actual numbers exceed this level, we would require alternative arrangements for additional patients, such as transfer to other facilities out with the Scottish Borders.

This will also need to be supported by nationally agreed and implemented ITU triage tools that are currently under development.

Staffing Model

NHS Borders has considered the staffing requirements for the COVID-19 general beds, 8 HDU beds, and 20 ITU beds.

This process has involved a review of all staffing levels related to current beds within the hospital and these have been reduced where possible while still maintaining safe registered nurse to bed ratio. These levels have been checked using a nationally released tool and are broadly in keeping with this guidance as it presently stands.

Other professions such as physiotherapy health care support workers and administration staff have been deployed to cover additional non registered nursing roles.

A system has been agreed where wards have been given a red, amber or green status which flags the level of staff on a daily basis which will allow clinical management to see the areas with the greatest staffing need at a glance. This will allow any additional available staff to be deployed quickly to areas that have a reduced number due to sickness.

Working With Partners To Reduce Delayed Discharges

By working closely with NHS Borders and Scottish Borders Council the IJB has already been operating a number of programmes specifically designed to reduce patient delay, increase flow and reduce the number of occupied bed days due to delays.

Building on these programmes, the Scottish Borders Health and Social Care Partnership response to COVID-19 was outlined in the submission made to Scottish Government on 2nd April. The response aims to bolster the locality response to maximise the resilience of our communities to be able to protect themselves, their families and their neighbours. It seeks to increase the capacity of provision, reduce process time and improve efficiency by eliminating all but essential requirements within governance and service operations. This approach will increase the ability of services to deliver to more people but it will still require further investment to increase the number of service hours available to meet the anticipated growth in demand.

All services within the partnership are expected to work across their professional boundaries, reducing the need to cater for households across several services. Data and intelligence sharing has already been agreed and technology enabled care and data transfer is supported both locally and across the Borders.

Our major aim, is to protect people in their homes, enable swift access to services as required, provide treatment and intervention efficiently and return people to their normal lives as soon as practically possible.

In this challenging time, we cannot provide our normal service, and our communities are aware of that. We are ensuring we offer the essential provision that will see our communities through this crisis, mitigating risks as fully as we are able.

The Scottish Borders Response follows six intervention themes as outlined below:

- Reduction of delayed hospital discharges
- Increase the capacity of both residential and home care
- Increase locality resilience
- Provide extensive support to both primary care and community provision
- Reduce administrative burden, quicken decision making
- Improve staffing capacity overall

More detail relating to the specific actions being taken under each area of intervention, along with expected outcomes, staffing implications and projected costs are outlined in the 2nd April submission to Scottish Government.

The steps outlined above are in addition to work that was already underway to reduce the level of delayed discharges in the Borders, which was outlined in the previous iteration of the Local Mobilisation Plan.

The submission on 2nd April included a revised trajectory to reduce delayed discharges in the BGH to 0 by 8th April and in Community Hospitals and Mental Health to 0 by 21st April which we have unfortunately not yet met.

To support patient flow from the acute settings and to provide additional Nursing Home bed capacity the Scottish Borders Health and Social Care Partnership has developed proposals for the establishment of a 14 bedded temporary Care Inspectorate Registered Nursing Care Home in Hawick. A suitable space was identified within an existing Care Home, Deanfield, and a task group was formed to develop the proposal and a model which could respond to the demands within the system and provide temporary safe and effective patient care. Staffing for this facility is now in place and patients are being assessed for admission. With this new facility we expect to return to our intended trajectory.

Medicines Shortages

The COVID-19 pandemic has affected services in many ways. The increased number of patients needing critical care has increased the demand for drugs used in both anaesthesia and critical care and this demand will need to be managed carefully.

NHS Borders has been acting in line with advice from National Procurement and Scottish Government during this time. The advice was to not stockpile as there was work on going to manage stocks across the UK and any excessive ordering could affect the supply.

Scottish Government and National Procurement are proposing that Scotland's share of UK procured stock for critical and supportive care medicines is allocated to Boards based on occupied ITU bed numbers. It is likely that no more than a week's worth of stock will be allocated at any one time. Atracurium the main muscle relaxant used for ventilation and intubation is likely to be out of stock in Scotland at the beginning of May. However, NHS Borders use has been less than expected, and our supplies are expected to be sufficient for now if it is not needed by other NHS Scotland hospitals.

Week commencing 6th April, Pharmacy Services were made aware of a UK shortage of propofol, a medicine used routinely for sedation of ventilated patients. DHSC and National Procurement are urgently sourcing alternative supplies. At present an alternative strength of propofol is available, however, this example demonstrates the fragility of the supply chain.

On 9th April we were made aware by Scottish Government of an issue with Fresenius who supply fluids for renal replacement therapy. NHS Borders has only received half of the order it was expecting and continue to chase for the remainder. As of w/c 20th April this still remains a critical issue and is being closely monitored.

A national group involving critical care doctors, pharmacists and senior managers has provided guidance on adaptations to first, second and third line treatments in the event that the preferred critical care medicines are unavailable. However, changes of practice in critical care due to shortages are likely to impact in other areas. For example a shortage of propofol and side-effects due to prolonged use will increase use of morphine and midazolam for sedation. This is expected to have an impact on supply for palliative care.

In order to mitigate the risks NHS Borders is:

- Reviewing stock levels and reporting to National Procurement on a daily basis
- Reviewing and adapting local practice, where demand for certain products is high, including switching to alternative routes of administration
- Considering combining sedatives (e.g. midazolam & morphine, propofol & alfentanil) following discussion with pharmacists.
- Reducing waste by working with clinical pharmacists and aseptic teams to devise safe ways to use all the contents of drug vials and ampoules.
- Liaising with Pharmacy aseptics to prioritise and maximise ready to administer intravenous medicines.
- Working with other Boards in Scotland to agree a process for sharing medicines and managing the risk of shortages.

Personal Protective Equipment (PPE)

We have now modelled our likely PPE requirements on a weekly basis projecting forward based on our activity assumptions and national guidance at this point. As a Board working to the assumption that we have sustained community transmission of the COVID-19 virus, our projections include the increased levels of protection that this level of risk assessment requires. The model does not yet include any impact of reinstating theatre lists.

Our daily top up and stock management systems are now in place and function across Acute, Community and Mental health teams, and our local PPE Committee has been established and is meeting 3 times a week to discuss operational issues and personnel protection requirements, which Social Care contribute to.

Access to fluid repellent gowns in high risk areas such as intensive care remain a particular concern given short supply issues noted nationally. NHS Borders is using stocks of reusable fluid resistant gowns with a turnaround of 4 hours in our local laundry and ASDU services. To support this NHS Borders has ordered additional reusable gowns. While this does not resolve the potential issues with the supply chain, it should allow the Board to prioritise and target available stock.

Eye protection continues to be an area of challenge. There is currently limited availability of nationally procured visors. Staff have raised concerns about the quality of nationally procured protective goggles and feedback from clinicians is that goggles are not always functionally appropriate to the tasks they are undertaking. The longer term picture in terms of supplies from the National Distribution Centre looks promising. NHS Borders continues to benefit from significant donations of visors from schools and local business which although not nationally procured have been locally assessed as suitable for use as a second line option. We have advised the practices to use the nationally provided eye protection as first line and to be aware that the locally produced visors have not been quality assured and do not bear a Kitemark.

Scottish Borders Council is overseeing the distribution of PPE to both its own care services as well as to external care providers. This work covers both residential care and home care. The voluntary sector is also being supported through the provision of their PPE.

There are five local hubs across the Borders, supporting local services and performing as distribution centres for PPE. There are adequate supplies available at the time of writing.

Mortuary Plan

NHS Borders participates in the Lothian & Borders Resilience Partnership sub group on Excess Deaths established on 1 April to examine solutions for the predicted deaths as a result of COVID-19. In addition we are working closely with SBC to monitor deaths and predicted deaths on a daily basis. Taking all the modelling information relating to COVID-19 and non COVID-19 deaths in the community SBC has commissioned additional temporary body storage which was made available from 20th April 2020 to support NHS Borders and undertakers' mortuary facilities.

NHS Borders has finalised a mortuary plan for managing and monitoring mortuary spaces during COVID-19 which dovetails with the local authority provision.

Shielding of Most Vulnerable Patients

Scottish Government has arranged that people at very high risk of mortality from COVID 19 receive a letter advising they should undertake 'shielding' by remaining at home for 12 weeks and limiting contact with other people. There are 7 categories of people requiring shielding of which two (4&7) required that individuals were required to be identified locally. Progress as at 21st April 2020:

ISD have issued the details of people in Borders who have received shielding letters:

- Batch 1: 1965 letters (categories 1,3 & 5)
- Batch 2: 620 letters (categories 2 & 6)
- Batch 3: 489 letters: locally identified patients up to 10.4.20 (categories 4 & 7 plus people missing from batches 2&3)

Additional patients:
Since 13th April we have forwarded details of 964 locally identified patients to ISD. At some point we expect these patient details to be issued to Boards in 'Batch 4'.

Calls to Patients

Scottish Government expects GPs to arrange calls to their patients to ensure the person understands how to keep safe and what support is available. NHS Borders offered support to practices to undertake these calls. Nine practices took up this offer equating to approximately 50% of total shielded patients.

To date calls to patients up to and including Batch 3 have been completed by call handlers and calls have commenced on locally identified patients received since 10th April. We are expecting from w/b 27th April that GP practices will undertake their own calls as the numbers for each individual practice reduce.

Support for Shielded Patients

GPs who identify patients locally can issue a letter from their surgery. This enables patients to receive information on keeping safe and the number for SBC's Community Assistance Hubs (CAH) pending letter being issued by ISD.

Local lists submitted to ISD are shared with SBC. This enables SBC to check what support is currently in place for these people and also to contact them with information about the CAH. Until 19 April this was done by phone and from that date this will be done by letter. On receipt of these batches GP surgeries are issued their patient list.

Primary Care colleagues are planning how best to support shielded patients to access health and social care services and remain safe.

Whole System Planning

As previously highlighted in earlier iterations of the LMP, NHS Borders along with colleagues in SBC are working actively to ensure a consistent and cohesive approach across activities within the Health and Social Care system. Internally, the COVID-19 response is being managed through the NHS Borders COVID-19 Pandemic Committee (Gold Command) which went live on 25 March 2020. The purpose of the Committee is to operationally oversee and manage the response of NHS Borders to the COVID-19 Pandemic.

Discussions with NHS colleagues in the East Region have confirmed our commitment to Mutual Aid wherever practicable and to continue to work together across the East Region Boards to ensure consistency of approach to levels of care.

Actions specific to the Acute Hospital can be found in earlier sections of this plan. Ongoing work underway to mobilise services across Mental Health, Learning Disabilities, Primary & Community Services and NHS Borders Corporate Services is outlined below:

PRIMARY AND COMMUNITY SERVICES (P&CS)

Our primary and community services are continuing to mobilise and respond to COVID-19. Below is a summary of the current position and the approach being taken:

Primary Care

The COVID-19 Primary and Community Services (P&CS) co-ordinating group continues to meet daily. Primary Care issues from all sectors are directed to a P&CS Emergency Planning Mail Box which is manned during working hours. The P&CS COVID-19 meeting reviews the queries each morning and agrees responses. At the end of the day key messages are agreed and sent out to GP practices in a daily update. Key messages for wider P&CS services are included within the daily Staff Update.

A new separate management on call rota to provide seven day Primary Care management has been introduced, and a workforce resilience system and process has been established in P&CS

based on a register of available staff capacity. The system supports the collation of staffing difficulties in GP practices and other services each morning and allows speedy deployment of relevant staff to support.

An Infection Control Helpline is in place for practices and services to access COVID-19 advice and support and interim additional 1.0wte senior medical COVID-19 support is in place in P&CS core team. In addition, P&CS has facilitated additional senior medical support to NHS24 and to a COVID-19 group linked to ITU / clinical decision-making,

Health and Social Care Partnership

We have now introduced 5 multidisciplinary locality hubs which support frail elderly, vulnerable patients and those who are at highest risk from COVID-19 and will require shielding. Transitional Care facilities have been created at two Care Home sites to allow patients waiting for Care Home placements to be transferred from community hospitals to support capacity. Work is currently underway to establish referral and transfer processes. We have agreement with GP colleagues that Care Homes will now dial GP practices in hours with clinical concerns rather than NHS 24 111 or 999 to enable speedy and appropriate clinical response and to avoid increasing demand on NHS24. A similar arrangement is in place with local out of hours services

General Practice

In mid-March the GP out of hours centre moved out of ED and into the vacated Day Hospital space on the BGH site to free up capacity in ED. There is a weekly meeting with our GP Executive to update on the situation, discuss issues and solutions. GP practices were moved to level 2 of Escalation Strategy at 6pm on 23rd March and have all remained at that level to date. There is daily contact between the COVID-19 lead in Primary Care and the Chair of GP subcommittee.

Since moving to Level 2 we have supported four practices with significant staff shortages associated with COVID-19 positive staff members by co-ordinating additional support – this has consisted of admin, nursing and pharmacy support in all four practices and GP support in one.

GPs (local, returning and new) are offering to support the COVID-19 Hub and Assessment Centre. We have an HR process in place to support non NHS Borders employees and have begun to deploy the additional medical resources to appropriate areas.

A draft Additional Hours LES is currently in development, we have clarified the requirements around pneumococcal vaccine for practices, have identified driver support for Dispensing Practices to support operational processes and GP prescribed oxygen has been stood down.

Dental Services

In response to COVID-19 all Public and Private Dentists in the Borders have cancelled routine appointments and treatment.

To ease pressure on NHS 24, created by an increased call volume, it has been agreed that the Public Dental Service (PDS) managed Dental Enquiry Line will remain open seven days a week between the hours of 8am and 6pm.

Patients are telephone triaged using the AAA principle (Advice, Analgesics and Antibiotics) this is supported by a process now in place that allows remote prescribing to take place. 'Near Me' is also being used where appropriate to provide remote consultations. This is helping to reduce the burden on the PDS and secondary care services allowing them to safely treat those that absolutely require treatment, through referral to the Urgent Care Centres that have been established.

Optometry

In response to COVID-19 services to Domiciliary and Residential/Day Centres have ceased, with telephone triage and telephones provided by Community Optometrists and the provision of spectacles to key workers continuing from Community Optometrists.

An emergency eyecare treatment centre (EETC) has been established at the BGH for the provision of face to face emergency eye care services to patients who have had a prior telephone triage and referred from a Community Optometrist. The EETC service delivery hours are Mon-Thursday 9am to 5pm, Friday 9am to 1pm. Out of hours service provision continues to follow the current eye service pathway. Actions have been agreed at a joint working group with Secondary Care (BGH Eye Service) to ensure establishment of EETC and the effective provision of emergency eye care to Borders Residents during COVID-19.

Community Pharmacy

NHS Borders Community Pharmacy Team has supported the supply of stock to support the GP out of hour's service and COVID Hub. They are currently meeting weekly with Community Pharmacy Borders (CPB) as well as daily contact by Lead Pharmacist for Community Pharmacy with Secretary of CPB to ensure a focus on maintaining essential services.

We have negotiated with Community Pharmacies to stop all non-essential face to face consultations for example Smoking Cessation consultation (supply of NRT will continue).

The following services will continue with mitigation actions taken:

Services	**Mitigation**
Smoking cessation counselling	Advise to use on-line support tools. Continue supply of products
Multi-compartment compliance aids (MCAs)	Maintain wherever possible, if services dictate a reduction then reduce to those who have family support or carer input initially.
ORT supervision	Reduce to supervising only those identified by BAS as very high risk.
CPUS	Maintain to reduce pressure on GP services. In event of Practice closure will require support to manage demand.
Emergency hormonal contraception	Undertake consultation over the phone. Discuss with Sexual Health services if any issues
NHS Pharmacy First / OTC sales	Establish queuing system observing social distancing
Opioid Replacement Therapy daily dispensing (ORT)	Reduce instalments to weekly except those identified by BAS as high risk
Medicines, Care & Review (MCR) and repeat	Dispense no more than 7 days in advance of when needed.

prescriptions	
Acute medication service (AMS) (dispensing prescriptions)	Extend wait times, discuss process with GPs to identify urgent prescriptions from routine requests

On 19th March 2020 all pharmacies were encouraged to reduce their patient facing hours by 1 hour at the start and end of their contracted hours, they were also encouraged to close for 1 hour over lunchtime. This was put in place across NHS Scotland to allow pharmacy teams time to process the exceptionally large numbers of prescriptions they were receiving for patients and allow time for cleaning of the premises.

On 22nd April 2020 all pharmacies were encouraged to return to their normal patient facing hours but to continue to close for an hour over the lunch period to allow time for cleaning of the premises.

All pharmacists and pharmacy technicians have been offered ECS access in line with NHS Scotland guidance. This will allow pharmacy staff to deal with medication queries from patients that otherwise would need to be referred to the GP practice or NHS24.

The NHS Borders community pharmacy team have worked with GDPs to put in place a process to allow prescriptions for urgent dental conditions to be emailed through to the pharmacy shared mailbox for dispensing.

The community pharmacy team have worked with colleagues in Palliative Care, BGH Pharmacy, Community Hospitals, Community Pharmacy, and the COVID-19 lead in Primary Care to raise awareness of the end of life drugs that may be needed and to ensure that stocks are available across the board for use at short notice.

The NHS Borders community pharmacy team have worked with colleagues in the Transport Hub, to ensure that community pharmacies have the resilience and capacity for deliveries; to support patients who have been advised to shield as well as those who have been advised to reduce their social contact.

In conjunction with the COVID-19 lead in Primary Care, GP Exec and NHS Borders Pharmacotherapy lead we have developed contingency plans to manage staff shortages in GP Practices, Community Pharmacies and Dispensing practices including full closure.

Nursing

As part of our Community Nursing response to COVID-19 we have identified vulnerable patient groups who will require additional support and re-adjusted rotas to provide robust cover throughout the week and weekend. Treatment Rooms are seeing essential / urgent cases with an alternative pathway in place to minimise footfall and clinical risk into health centres. We have redeployed Dental staff and others to shore up stretched services across primary and community services and have established a Buddy System for Nurse Team Leads to support resilience. Nursing staff are also participating in Locality Group Working to prevent admission and work together across the partnership.

Community Hospitals

Within our Community Hospitals all visiting has ceased and walk in minor injuries have been suspended with an alternative pathway in place. A relaxation of geographical admission criteria is in place to make best use of limited bed capacity and a Nurse-led team is working to support timely patient discharge from community hospitals to ensure bed capacity for patients requiring transfer from acute care.

The service is modelling length of stay, estimated length of stay, estimated dates of discharge and delayed discharges within Community Hospitals to ensure capacity and flow is maintained

NHS BORDERS COVID-19 HUB AND ASSESSMENT CENTRE

In line with Scottish Government requirements NHS Borders has established a COVID-19 Community Hub and Assessment Centre with agreed pathways through a telephone hub through which senior decision makers to triage patients over the phone and an assessment unit equipped to assess COVID-19 related presentations.

The Borders facility was established on 23rd March and is located in the Day Hospital in the BGH alongside the GP out of hours service. The Day Hospital can provide capacity to scale up to approximately 120 patient assessments per day and staffing plans are in place to deliver this. Modelling has confirmed that this should be sufficient to absorb predicted demand. Initial contingency plans for any surge in demand greater than the available capacity was to initiate a combined ED/COVID-19 assessment area in the BGH. Further modelling work however has indicated that this will not be required. The revised contingency for this service is now the use of a tented facility that has been erected in the BGH car park adjacent to a drive through testing facility.

MENTAL HEALTH & LEARNING DISABILITY SERVICES

As highlighted in previous iterations of the LMP, in general all services have moved to a scaled down service, prioritising high risk patients/service users for telephone contact minimising face to face contact and maximising social distancing amongst staff and patients/service users. Some staff have been temporarily redeployed to support services with staffing shortages both within and outwith Mental Health and Learning Disability Services.

Within the Mental Health Inpatient service we have temporarily relocated an older adult's mental health ward into our acute admissions ward to free up in patient capacity within Borders General Hospital. Given the change in assumptions around required inpatient capacity within the BGH it has been agreed that the older adults mental health ward will now return to its original accommodation. Should demand increase significantly then this decision can be revisited. Delayed discharges are a priority focus to create capacity for any new admissions and significant progress continues to be made.

In order to support GP practice with referrals during the pandemic we have expanded the remit of our Well Being service to provide an enhanced triage of referrals and provision of additional short term psychological interventions including signposting and face to face contact. Initially this will run for 3 months. Support is also being provided from within our psychology workforce to focus

on supporting staff wellbeing across NHS Borders. A staff wellbeing service has been launched from 9th April.

Additional nursing capacity has been made available to out of hour's services in anticipation of the redeployment of some medical staff into acute medicine and the CMHT's are now managing crisis calls during office hours Monday to Friday.

Within Learning Disability services there is considerable support being provided to commissioned services to maximise the resilience of providers anticipating considerable staffing shortages over the coming 2 – 3 months.

WHOLE SYSTEM PATHWAY PLANNING

Discussions were held in early April to agree in advance pathways for patients with confirmed and suspected COVID-19. The focus of these discussions initially was around the transfer of patients from the BGH to Community Hospitals and confirmed through a Standard Operating Procedure. This has since been widened to include discharge to Care Homes. These pathways are in line with national guidance. Further support is in place for both Council Care Homes and external Care Homes; daily information is collated from every Care Home within the Borders, with early COVID-19 alerts regarding both staff and residents. As was detailed earlier a further Residential Nursing Care facility is being opened with 14 beds to further support the pathway.

DIGITAL / eHEALTH

Rapid work has been undertaken by IM&T staff to support the mobilisation of NHS Borders to be able to respond to the COVID-19 pandemic. Staff within IM&T have supported reconfiguration of the BGH inpatient wards supplying additional equipment, network points, Trak configuration and user accounts for access to systems. Similar support has been given to the COVID-19 Hub & Assessment Centre and now to the staff testing service.

A number of additional NHS Borders staff have been provided with laptops to work remotely, either for home working or for district nurses etc working in the community. So far 123 laptops have been allocated and up to 325 people are working remotely at any one time.

GPs and some of their staff have been given remote access tokens to work during isolation. A total of 43 tokens are already allocated with 50 more ordered.

IM&T are working with the lead for GP Resilience to ensure practices will be given access to any relevant patient information.

25 iPads have been supplied for patient use to BGH wards and 4 have been supplied to Mental Health wards and 1 for use by Learning Disabilities. There are an additional 20 iPads due for delivery.

Near Me and MS Teams roll-out has been a priority. Calls using Near Me have increased daily, with Mental Health Services and Children's Services embracing this way to consult with their patients. General Practices are starting to use this and the COVID-19 Hub is using this as part of their triage. We are now working on the priority areas defined by Scottish Government in Outpatients areas and will soon have a central virtual reception up and running to manage and

direct patients as the link in for their Near Me appointment. Calls rose to over 571 in total by 17th April and are increasing daily.

MS Teams accounts have been created for over 3,000 staff for use over a web link. Meetings are now starting to be held via Teams across the organisation. The contract resource which was due to undertake our mail migration has been used to support this Teams work and so we have a gap in moving mail which will need to be addressed.

Over 240 headsets and 140 webcams have been supplied to assist with the use of Teams and Near Me with requests being fulfilled daily.

The 2 internet facing links in the BGH have been upgraded; the BT link and the SWAN link have both been uplifted. These changes should help some of the challenges with connectivity over the internet.

We are exploring options to bring patient Wi-Fi connectivity to the Community hospitals ahead of the implementation of a permanent solution. Testing is underway of a temporary G4 hub, if testing is successful this solution will be rolled out into all community hospitals and they will be supplied with iPads for patient use.

Complex work has been undertaken to provide NHS Borders staff with access to the SWAN network from The Scottish Public Pensions Agency in Tweedbank and is ready for use should the decision be made to utilise this space.

A radio link to supply the Testing center in the car park with access to NHS Borders network has been arranged and is due to be installed 21st April. Hardware including PCs and printers is ready to be installed once the structure is in place.

IM&T have implemented and are now working on an enhanced level of out of hours service.

The Business Intelligence team has supported creation of reports to assist in managing and monitoring the COVID-19 pandemic including daily reporting both locally and to Scottish Government. This has been very challenging at times securing the right data to make sure this accurate with significant manual effort – work continues to try to automate and streamline this.

Medical records teams are responding to the different requirements of them and are being offered up to be redeployed to other services in NHS Borders who may require additional staff to support their COVID-19 response.

Many suppliers have made contact and have offered assistance. We are reviewing these to see what is most helpful and also working with national colleagues to see what we can learn and implement in support of the overall COVID-19 digital response.

As highlighted in earlier iterations of the LMP, there are a number of risks and issues which have been identified at present, and as outlined below:

- As with all services staffing and keeping the team well remains a concern – there is limited cover for some skills

- We have some concerns that the Wi-Fi network can cope with the voice and video traffic and plan to get an external independent review to help us be assured and confident in the configuration to give more certainty of capability

- Cyber security – there is an enhanced threat level and we are being advised (expect to be mandated) to implement ATP –(Advanced threat Protection) – this will mean some of our resources need to be directed to this work and may affect other COVID-19 work

- Trak configuration – the speed of making floor plan changes to Trak has left us with a possible data legacy issue that may take some time to unpick and recover from which could affect all our reporting as we try to go back to more usual definition of beds

CORPORATE SERVICES

Business Continuity plans for all support services are now in full operation with all non-essential business as usual stood down. All Corporate and support services have identified over 170 staff with varying and flexible skill sets to re-deploy to a number of activities.

A number of activities are currently underway in order to ensure that requests are responded to as efficiently as possible:

- The Financial Turnaround PMO have now been set up as a central hub with all requests for additional staff being logged, actioned and allocated
- Call centres are being established for NHS Borders to deal with staff sickness absence, Occupational Health advice and support and any other general enquires
- Accelerated training sessions for staff to be equipped to undertake additional/alternative roles

A number of functions are also now being set up and resourced, these include:

Dedicated Absence Line for All Staff

The implementation of a new Call Centre to manage staff absence has been progressed on a phased approach, working closely with the Board's Staff Hub Service to record, report and manage all absence within Clinical and Non Clinical services, to enable staff rosters and staff availability to be maintained at the required levels, on an individual service by service basis, as appropriate.

The implementation of the Absence Call Centre function has been communicated to affected staff via various communication forums, including the Staff Involvement Global email distribution, as part of the COVID-19 daily email update and directly by email to the Line Managers of each staff group as staff groups are directed to use the line.

Staff Accommodation Hub

NHS Borders recognises the importance of supporting and protecting our staff whilst trying to maximise staff availability as much as possible.

On an entirely voluntary basis, staff members who meet the eligibility criteria can be offered free accommodation as required. Accommodation is available to staff working across all NHS Borders localities provided they meet the eligibility criteria.

Subject to availability, NHS Borders will arrange accommodation for staff members who meet any of the following criteria:

- There are members of their household who are self isolating because they are experiencing COVID-19 related symptoms and the staff member (provided they meet the criteria for testing) has tested negative for COVID-19 and is unable to return home.

- The staff member or new recruit is/will be working with NHS Borders on a temporary basis to support the fight against COVID-19 and they are working away from home.

- The staff members depends on public transport for work but due to changes to bus/train timetables would find it challenging to get to or from work for their shift start and end times and the transport hub has been unable to secure transport.

- The staff member requires emergency accommodation due to an urgent response or mitigating factors – for example, the staff member is asked to work a number of back to back shifts and provided accommodation would allow the staff member to sleep nearby in between shifts and would minimise disruption to their family members, who may be socially distancing (the staff member may or may not travel some distance to work).

Patient and Family Liaison Service

The role of the Patient & Family Liaison Service is to ensure that there is a process in place to support communication with and to patients and their families during the COVID-19 Outbreak. The service will be triggered if clinical demand increases. This service will provide two arms of support, one for families who can no longer visit to ensure they are kept informed of their loved ones progress whilst in hospital and the second as a single point of contact for patients receiving specialist care. This would be triggered if specialist teams are drawn in to support the frontline response to caring for patients with COVID-19. The service is also facilitating the new process for Medical Certificate Cause of Death (MCCD) resulting from families being unable to physically access local registrar offices. The service is ensuring that following the death of an inpatient the next of kin is contacted to provide support and to give them access to the MCCD.

Staff Deployment Hub

A detailed directory of all staff that could be redeployed from services across NHS Borders has been developed. Any external staff that have been added to staffing banks in support of COVID 19 have also been added to this directory. These staff have been offered training as Healthcare Support Workers, return to practice training as Registered Nurses or have added to a bank for administrative posts required in response to COVID 19. As Clinical Board plans have developed staff from the directory have been matched and allocated to support the workforce plan to increase bed capacity, initiate COVID assessment hubs, staff testing services and enhance capacity in community teams to provide resilience for staff absence. As plans evolve staff continue to be deployed where service need is identified.

Volunteers

NHS Borders has a large volume of volunteers however to date we have not called our volunteers in to roles to support the COVID-19 response given the large number of paid staff who have become available for other duties due to business as usual activities being stood down at present.

Transport Hub

The transport hub has been established primarily to manage transportation requests for COVID-19 positive or suspected positive patients to and from the COVID-19 Assessment Centres, who have no access to their own transport as patients must not use public transport; patients being discharged from ED1 (suspected COVID-19) and discharges from COVID-19 wards.

The transport hub is operational 08:00-20:00 7 days a week and normal out of hours arrangements are in place out with these hours.

Over time, the transport hub has picked up other work, mostly related to transport demand as a result of the Covid-19 pandemic, where there are no other services available to provide this.

The transport hub is also currently supporting other functions and services in direct response to COVID-19 which include:

- Transportation of dialysis patients
- Delivery of COVID-19 swab tests to NHS Lothian 3 times per day - 7 days per week
- Delivery of Cytoxic drugs (Chemotherapy) to patients 4 days per week
- Co-ordination of community pharmacy prescription deliveries to patients
- If capacity allows transportation of other discharged BGH patients to home
- Future possible transportation needs including:
    - Delivery of doorstep COVID-19 test kits to patients
    - Transportation of patients to and from emergency dental and optometrist centres which are to be opened

Clinical Governance

Existing systems and processes for clinical governance remain in place and patients and families have been advised usual timescales for response to complaints and significant adverse events will not be delivered as a result of the organisations response to COVID-19. Events which would trigger the Duty of Candour are also being monitored whilst it will not always be possible to adhere to the recommended timeframes for enacting each step of the Duty during COVID-19. NHS Borders continue to work proactively with partner organisations such as the Scottish Public Sector Ombudsman and the Central Legal Office to maintain a timely response to their queries where possible.

Quality and safety datasets continue to be monitored to ensure the safe delivery of services. Participation in national and local improvement initiatives has been paused to enable the organisation to deploy all resources to the pandemic response.

The Board Clinical Governance Committee (CGC) met as planned in March 2020 and provided a focus on organisations response to COVID-19 with specific consideration of where thresholds of treatment and the scope of practice may need to be adjusted as patient demand increases. Following consideration at the CGC a statement was issued in Support of All Professionals, Staff Groups and Independent Contractor Colleagues to detail the organisations support for them and roles they are required to fulfil in response to COVID-19.

Ethical Framework

NHS Borders has established an Ethical Advice and Support Group to provide advisory support during COVID-19 with the aim of making ethical use of potentially limited health resources and to do so with transparent, consistent and equitable decision making support. The Group has been developed to have a flexible approach and be readily available and able to offer timely support to clinical teams and to the Chief Executive relating to:

- Complex decisions around withdrawal of care
- Situations where clinical decision makers feel uncomfortable with the application of national guidance
- Challenging decisions around escalation planning and ceilings of care
- Complex decisions related to patient discharge due to high clinical demand
- Challenges related to reduced ability to provide normal standards of care, in particular in the community or for patients at the end of their lives

The Group is guided by a set of ethical principles and guidance, where available, from national bodies and professional groups.

Covid-19 Testing

Staff Testing

NHS Borders Staff Testing Facility provides a 7 days service to support business continuity of Health and Social Care critical services. It is expected to change depending on changing risk assessment/national guidance. The availability and timeliness of this testing service is subject to laboratory capacity. Hospitalised patients will be prioritised for testing. Thereafter it will be the household members of asymptomatic key workers. Symptomatic key workers will benefit least from testing due to the shorter period (7 days) needed before returning to work.

The current facility is currently sited at Borders General Hospital. Testing is performed whilst the member of staff/household member remains in their car. The test is a throat and nasal swab (undertaken within 72 hours of symptom onset). Testing is held by appointment only and is available 7 days a week.

NHS Borders is in the process of establishing a drive through testing facility at Borders General Hospital, which will replace the current facility. This will be primarily used for testing staff including staff from the NHS, Pharmacy, General Practice Staff, Scottish Ambulance Service, SBCares Staff, Independent Care Homes and Care at Home Services.

Care Home Testing

NHS Borders has the capacity to provide tests to Care Home staff and care at home staff or Care Home residents in line with Scottish Government guidance. This builds upon our established staff testing model (a robust pathway for workers, or people in their households, to access testing from a single point of contact), with Board testing staff attending in the first instance to provide tests but then also training to appropriate staff within the Care Home. This rolling programme will limit additional footfall into vulnerable areas such as Care Homes.

Enhanced Surveillance

As highlighted in our previous LMP, NHS Borders will implement the required Enhanced Surveillance function for COVID-19 through our Hub and Assessment Centre. This has been scaled by Board size and means that we are required to provide on a daily basis (Monday to Friday) two from the hub and four from the Assessment Centre.

Opening Up Extended Testing for Key Workers

The Scottish Government has set out a prioritisation matrix for identifying which key workers should be able to access the UK Testing Programme at the UK Testing sites. Health and social care workers, along with staff working in residential settings should continue to access testing through our local testing facility, as highlighted above. The only exception to this is those health and social care workers who are not employed through an organisation such as social care personal care assistants, and unpaid carers who should access testing through the UK Testing Programme.

Contact Tracing

Scottish Government is moving towards a 'Test, Trace, Isolate, Support' approach. A National Planning Board is being established and will provide guiding principles for local Health Protection Teams to use for planning purposes. It is expected that elements of the contact tracing service could be delivered nationally, regionally or locally. NHS Borders is in the process of establishing a Contact Tracing Steering Group with the purpose of developing local plans in line with national guidance.

Patient Testing in Hospitals

In light of national recommendations in relation to testing patients for COVID-19 having been updated, all patients aged 70 and above who are being admitted to an inpatient facility, including community hospitals and mental health wards, will be screened for COVID-19 with a combined nose and throat swab. Over the coming few days we will look to achieve equity of access to tests for existing inpatients aged 70 and over. There are also criteria for swabbing patients prior to discharge to Care Homes with 2 negative swabs required for patients with previous positive tests on the current admission. A single previous negative result is required for negative patients being discharged to a Care Home. Work is underway to develop patient pathways for these new testing requirements and further details will follow in due course.

Workforce Challenges

The National Portal

The portal brought together all the recruitment leads across NHS Scotland and supplied NHSB with a large number of names and professions. The process used to recruit the individuals struggled to be sufficiently agile to allow NHSB to recruit individuals at pace. The NHSB recruitment section identified individuals and by using a shortened recruitment process, was able to bring people into the workforce more quickly. The use of Bank/as and when, appointments allowed for more flexibility to address the needs of the service.

Staff Governance

Staff are kept well informed with the introduction of daily communications. Partnership working continues in the organisation on a remote basis to ensure that staff are involved in decisions which affect them. Training has been provided in a focused way to ensure that all staff are prepared to deal with the changing clinical environment. We have ensured staff have been treated fairly and consistently during the deployment. Managers are encouraged to discuss any issues staff identify to ensure that they are addressed appropriately in a values based way. The development of a wellbeing plan has looked holistically at the needs of staff, introducing an emotional support programme. Proactive communication with our population and encouragement of volunteering ensures that the wider community is involved.

Annual Leave

As an essential part of planning resources to cope with the anticipated demand arising from the COVID-19 pandemic, Clinical Boards reviewed annual leave plans with their teams for a 4 week period commencing 6th April 2020 and as a result some leave arrangements were altered. A Scottish Government circular details the importance of staff getting time off for rest and recuperation, emphasising line managers will have to carefully balance service needs with individual staff requests for time off during this period. Staff will be able to carry forward any leave they were unable to take over the last few months of leave year 19/20 and will be able to take this over a 2 year period up until 31 March 2022. In some circumstances, there may be the facility to request to have some of the leave paid out.

The Scottish Terms and Conditions Committee (STAC)

The STAC is a partnership organisation which exists to collectively negotiate terms and conditions issues for NHS Scotland staff other than those which pertain exclusively to recognised separate collective bargaining arrangements. In response to Coronavirus (COVID-19) STAC has been working in partnership to agree changes and additions to terms and conditions which gives services the flexibility and support it needs at this time. Key areas where amendments have been made include: overtime payments; annual leave; starting salaries; sick pay entitlement; fixed term contracts; organisational change protection and Bank Worker entitlements.

Shielding

NHS Borders has employees who have received the Government's letter asking them to stay at home at this time. They are unavailable for work. These are colleagues who have a particular vulnerability, as regards COVID-19. These staff members remain on payroll, receiving income. There are also staff members who do not fit this category but who do nonetheless have other significant health issues. Line managers have identified these staff and worked with Occupational Health & Safety and Infection Control colleagues to assess risk. Many of these workers have been deployed to Non-COVID-19 areas and provided with Personal Protective Equipment.

Death in Service

NHS Borders has an HR protocol to support managers in the sad event of an employee's death. It is essential that these situations are handled in both a sensitive and effective way to prevent any additional distress for the next of kin, relatives and colleagues. Following the protocol ensures that the next of kin will be treated in a respectful, sympathetic and supported way whilst also ensuring practicalities are dealt with, for example, payment owed to the deceased staff member's estate and reclaiming the organisation's property. The protocol details the roles and responsibilities for the line manager, HR, OH and Finance along with the inclusion of a manager checklist and process chart to provide guidance through the process.

Staff Wellbeing

Staff Wellbeing is a priority within NHS Borders and we have now set up a psychological wellness hub within the Work and Wellbeing Department. This is led by NHS Borders psychological services and overseen by the Head of Psychology.

Early Financial Assessment

Plans for Health and Social Care have been agreed in principle by Scottish Government, with retrospective approval for specific funding allocation expected to be confirmed following detailed review of financial models.

With the exception of Deanfield care home capacity, resource plans have been implemented to end June 2020 in the first instance, to be reviewed monthly from end May unless trigger points for hospital capacity are exceeded in advance of this timescale. The Deanfield plan has been approved for a six month duration through the escalation process agreed for actions which exceed health board delegated limits.

The estimated financial impact of the actions identified within this report remains subject to significant uncertainty, particularly in respect of the phasing of actions beyond the initial "first wave". The consolidated forecast for both health & social care to end June 2020 is £7.6m with a further £13.4m projected to end March 2021. This forecast assumes that service levels, including hospital bed numbers, remain at the adjusted level agreed for the pandemic peak as highlighted above.

Systems of internal control have been established to ensure that all NHS costs reported against Covid-19 related spend are appropriate and include consideration of offsets where available. The board continues to participate in national and regional benchmarking via the Corporate Finance Network to provide further assurance, including review of social care costs included within the H&SC section of the LMP finance template submission.

Risk Management

COVID-19 is significantly impacting on the business of NHS Borders resulting in a rapid pace of change into unchartered public health and service issues. The strategic risk covering COVID-19 has been added to the strategic risk register for NHS Borders. The key operational risks for NHS Borders associated with management of COVID-19 need to be identified and addressed. To support the organisation to do this a COVID-19 risk register has been created. Due to pace and capacity the COVID-19 register is a rationalised format of the full risk register with a view to documenting only critical/high risk issues. All risks have a designated risk owner and are considered by the Pandemic Committee on a regular basis.

All health and safety risks that have long term implications arising will continue to be recorded under the normal risk assessment process to ensure we are covering our legal responsibilities of providing suitable and sufficient risk assessments.

Recovery Plan

We are taking forward developing a recovery plan. This is being progressed on a clinical board basis with a focus on what we can put in place the next few weeks, how we manage services going forward taking account of lockdown, social distancing and shielding as well tackling the impact these issues have had on our demand, finances and service models. We plan to capture the experience of the last few weeks and take action on what we have learned. Staff recovery, support and ownership will be fundamental to the success of the plan.

Next Steps

This is the fourth iteration of the NHS Borders Local Mobilisation Plan and it is intended this will be the last plan to respond to COVID-19. Any decisions required that are not in line with or not referenced already in the plan will be made through the Pandemic Committee structure that has been put in place or through the usual governance arrangements should the Committee be stood down.

1st May 2020